IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2020-485-

In the Matter of an application under the Judicial Review Procedure Act 2016 and the Medicines Act 1981 and the Fair Trading Act 1986 and the NZ Bill of Rights Act 1991 and Health and Disability Commissioner Act 1994

Between **NGA KAITIAKI TUKU IHU MEDICAL ACTION SOCIETY INCORPORATED,**
Plaintiff

AND THE MINISTER OF HEALTH
First defendant

AND THE DIRECTOR GENERAL OF HEALTH
Second defendant,

AND **CHRISTOPHER JAMES**
Third defendant

AND **THE PRIME MINISTER OF NEW ZEALAND**
Fourth defendant

AND **THE MINISTER OF COVID RESPONSE**
Fifth defendant

AND THE ATTORNEY GENERAL
Sixth Defendant

AFFIDAVIT OF DR SIMON THORNLEY
IN SUPPORT OF PLAINTIFF
DATED 21 April 2021

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Affidavit of DR SIMON JAMES THORNLEY

Dated 21 April 2021

I **DR SIMON JAMES THORNLEY** of Auckland, public health medicine specialist and epidemiologist, swear:

Summary of my personal expertise

1. I am a public health medicine specialist and epidemiologist. I am trained in medicine, public health and have a particular interest in epidemiology, having completed a PhD in this area in 2014. Since then, I have worked on general epidemiology projects in planning and funding in the Counties Manukau District Health Board, Regional Public Health, and in the Section of Epidemiology and Biostatistics at the University of Auckland School of Population Health. I currently work at the University of Auckland and I teach epidemiology and biostatistics to undergraduate students there.

2. I am also engaged in researching the epidemiology of infectious diseases, at present centred on the prevalence of scabies in Auckland and the role of this infection in the aetiology of acute rheumatic fever. I was involved in past public health responses to novel respiratory infections, such as swine flu, and until late 2019 was advising Auckland Regional Public Health Service about the threat posed by Covid-19, in a part-time capacity.

3. A copy of my CV, including my academic publications is annexed marked "SJT-A".

4. I have read the High Court Code of Conduct for Expert Witnesses and have complied with the code in my preparation of this evidence.

B. The expertise of the Plan B team and our reason for being

5. I am one of a group of New Zealand academics who developed a strategy known as "Covid Plan B" in April 2020. The group has members with expertise in the areas of public health, epidemiology, pacific health, law, economics and biostatistics. I am the spokesperson for this group.

6. Covid Plan B proposes a more moderate and orthodox response to Covid-19 than the response adopted by the New Zealand government.

7. The Covid Plan B strategy is for focused protection of the frail and elderly, who are most at risk of fatality from Covid-19, whilst avoiding lockdowns and border closures.[1] The Covid Plan B strategy is consistent with orthodox public health responses, based on the nature of the threat.

[1] https://www.covidplanb.co.nz/our-posts/why-does-new-zealand-need-a-plan-b/

8. The Covid Plan B strategy was developed due to concern that the nature of the threat from Covid-19 was grossly overestimated[2] and was disproportionate to the risks from Covid-19. We were concerned about the government's narrow focus on Covid-19 at the expense of other public health, wellbeing and economic considerations.[3] We were also concerned that the high financial costs of the government's strategy outweighed any benefits.

C. Summary of Plan B, the risks of Covid-19, the government's response and alternatives.

9. By April 2020, senior epidemiologists globally were questioning the severity of Covid-19 and arguing that the policy response of many government's was disproportionate to the risk.[4]

10. I had been involved in New Zealand's response to the H1N1 (swine flu) epidemic. We realised then that the threat posed by the virus was exaggerated early in the apparent 'pandemic'. Later the response was reduced, since the virus was found to be almost ubiquitous in New Zealand.[5] This evidence came while the public health response was still focused on containing the risk of spread of the virus. In other words, the apparently deadly novel virus had already spread around New Zealand with little effect on the health care system, while public health authorities were trying to reduce the spread through public health measures, including quarantine and contact tracing.

11. I felt that it was important that this experience of swine flu and the response be integrated into the response to Covid-19, since a similar situation could occur with the response to Covid-19. Information from overseas concurred with this assessment. Serology, indicating cumulative exposure to the SARS-CoV-2 virus, showed that infection was much more widespread than was initially believed (from genetic PCR tests).[6] The evidence showed that many people had developed immunity without knowing they had been exposed to this virus, indicating that the virus was much less deadly than initially believed.

12. Instead of instituting a serology survey, as occurred in response to swine flu, the government outlawed the use of such tests for SARS-CoV-2.[7]

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[2] https://www.covidplanb.co.nz/our-posts/is-new-zealands-covid-19-story-past-its-use-by-date/

[3] Lee A, Thornley S, Morris A J, Sundborn G. Should countries aim for elimination in the covid-19 pandemic? BMJ 2020; 370 :m3410 doi:10.1136/bmj.m3410

[4] https://www.statnews.com/2020/03/17/a-fiasco-in-the-making-as-the-coronavirus-pandemic-takes-hold-we-are-making-decisions-without-reliable-data/

[5] https://www.health.govt.nz/system/files/documents/publications/seroprevalence-flu-2009.pdf

[6] Ioannidis JPA. Bull World Health Organ 2021;99:19–33F doi: http://dx.doi.org/10.2471/BLT.20.265892

[7] https://www.covidplanb.co.nz/epidemiology/nz-govt-confirms-it-wont-test-for-virus-prevalence/

13. Countries, such as Iceland, who had extensively tested both symptomatic (people with symptoms of a chest infection) and asymptomatic (healthy) people showed that the virus was much less deadly and more widespread than initially claimed. From the Iceland data, it was clear that only about 1/20 (5%) of people who tested positive for Covid-19 from genetic (PCR) tests were hospitalised and that only 1/100 (1%) required intensive care treatment.[8]

14. Fatality rates, which were estimated to be high early in the Covid-19 episode were later shown to be much lower, when the results of antibody tests were accounted for. Linked with this, was the finding that the age distribution and median age of death from Covid-19 was similar to background death.[9] By "background death" I mean the death rate of the population without exposure to Covid-19.

15. Our shared concern about the policy over-reaction to the virus led us in early April 2020 to advocate for a more focused approach to mitigating the threat posed by Covid-19. This consisted of sheltering elderly and infirm people, increasing infection control policies particularly in hospital and elderly care homes, and conducting serosurveys to assess the extent of spread of Covid-19 in New Zealand.[10]

16. Since this time, such a strategy has been articulated by an international group of leading epidemiologists, "The Great Barrington Declaration", and Plan B has supported this approach.[11]

17. Since then Plan B members have been involved in writing about other topics that have emerged as part in relation to the government's response to Covid-19. These include:
    a) The overuse of ventilation in intensive care which exaggerated the fatality of Covid-19 overseas.[12]
    b) The exaggerated prediction of mass fatality from mathematical models relied on to justify lockdowns in New Zealand.[13]
    c) Mathematically modelling border policies related to the selective opening of New Zealand's borders.[14]

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https://gazette.govt.nz/notice/id/2020-go1737

[8] https://www.covidplanb.co.nz/our-posts/what-can-we-learn-from-iceland-about-covid-19/

[9] Ioannidis, J.P.A., 2020. Global perspective of COVID - 19 epidemiology for a full - cycle pandemic. European Journal of Clinical Investigation 50. doi:10.1111/eci.13423

[10] https://www.covidplanb.co.nz/our-posts/why-does-new-zealand-need-a-plan-b/

[11] https://gbdeclaration.org/

[12] https://www.covidplanb.co.nz/our-posts/the-surprising-story-of-how-ventilation-killed-covid19-patients-in-intensive-care/

[13] https://www.covidplanb.co.nz/our-posts/govt-policies-must-catch-up-with-latest-data-on-covid19/

[14] Smith, B. J., Morris, A. J., Johnston, B., Child, S., & Thornley, S. (2021). Estimating the effect of selective border relaxation on COVID-19 in New Zealand. The New Zealand Medical Journal (Online), 134(1529), 10-25.

d) Questioning the evidence for the use of masks to prevent Covid-19 infection, based on randomised trial evidence.[15]
e) The exaggerated coding of Covid-19 fatalities in New Zealand and overseas that have propagated fear, and been used to justify extreme policy measures to contain the virus.[16] This concern refers to Covid-19 being routinely cited as the cause of death if the deceased tested positive for Covid-19 in the 28 days prior to the death. In fact many of these deaths were "with" Covid-19 not "from "Covid-19".
f) The finding of widespread infection from SARS-CoV-2 in Italy in September 2019, predating the official emergence of the virus in Wuhan. This evidence questions the use of lockdowns and border controls to limit viral spread, and instead indicates that excess mortality observed in some countries was largely a result of the policy response to the virus.[17]
g) The age distribution of death from Covid-19 is no different from the age distribution of background death, indicating that the virus is not especially virulent or deadly.[18]
h) Holding international online symposia to canvas a variety of scientific views on the response to Covid-19.[19]
i) Critiquing the simplistic government messaging about the safety and efficacy of the experimental Covid-19 mRNA vaccine against the published evidence.[20]

D. Risks and uncertainties etc of relying on the novel mRNA Vaccine

18. I am concerned about the rushed nature of the rollout of novel mRNA vaccines, including the Pfizer mRNA vaccine, that are currently being used. While the stated aim is to improve population immunity to Covid-19, I am concerned that these vaccines may poses an unjustified threat to the health New Zealanders. I have several reasons for my concerns.

19. Firstly, I am mindful of the usual means of deciding whether a vaccine is warranted for a population. This is usually based on cost-benefit analyses and comparing the proposed intervention with other health interventions based on an assessment of how many "life years" are saved by the vaccine,

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https://www.nzma.org.nz/journal-articles/estimating-the-effect-of-selective-border-relaxation-on-covid-19-in-new-zealand

[15] Thornley S, Jackson M D, Sundborn G. Danish mask study: masks, media, fact checkers, and the interpretation of scientific evidence BMJ 2020; 371 :m4919 doi:10.1136/bmj.m4919

[16] https://www.covidplanb.co.nz/our-posts/determining-cause-of-death-in-the-age-of-covid-19/

[17] https://www.covidplanb.co.nz/our-posts/govt-policies-must-catch-up-with-latest-data-on-covid19/

[18] https://www.covidplanb.co.nz/our-posts/is-new-zealands-covid-19-story-past-its-use-by-date/

[19] https://www.covidplanb.co.nz/symposium2021/; https://www.covidplanb.co.nz/symposium2020/

[20] https://www.covidplanb.co.nz/our-posts/injecting-evidence-into-the-vaccine-spin/

the side-effects of the vaccine, and the cost of administering them.[21] To my knowledge, such an assessment has not been carried out for the novel mRNA vaccines.

20. Secondly, and relating to this issue of economic justification, is the very low fatality rates of Covid-19 in people under the age of 65 years.[22] Since the risk of death is so low, it is hard to justify the emergency use of an experimental vaccine, where the long-term safety and efficacy of the product are unknown.

21. An important risk of the vaccine which has not been fully evaluated, is that of antibody-dependent enhancement. This is a phenomenon in which the difference between two sequential, but related serotypes of viruses can compromise the ability of the first infection to neutralise the second one. Such a mechanism has been demonstrated in the response of various mammals to the closely related SARS-CoV vaccines, and can lead to paradoxical increased severity of infection.[23] Such risks of the new vaccines have not been fully evaluated.

22. The effects of the Pfizer mRNA vaccine on hospitalisation and death from Covid-19 is not known.[24] The clinical trials only started late last year and are not due for completion for another two years. Risks or efficacy have not been researched at all for more vulnerable populations who were excluded from the preliminary stages of clinical trials for these novel vaccines.

23. At the same time, evidence is emerging that hospital fatality rates from the infection are falling,[25] due to improved treatment and less aggressive use of ventilation to treat infections. The use of supplemental vitamin D[26] and ivermectin[27] are also promising new treatments which are likely to substantially improve survival and reduce the threat posed by the virus.

24. I am extremely concerned that the risk and uncertainties of exposing the entire New Zealand adult population to a novel vaccine which has only

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[21] https://link.springer.com/article/10.1007/s10389-008-0199-4

[22] https://www.sciencedirect.com/science/article/pii/S0013935120307854

[23] Eroshenko, N., Gill, T., Keaveney, M.K. et al. Implications of antibody-dependent enhancement of infection for SARS-CoV-2 countermeasures. Nat Biotechnol 38, 789–791 (2020). https://doi-org.ezproxy.auckland.ac.nz/10.1038/s41587-020-0577-1

[24] https://www.covidplanb.co.nz/our-posts/injecting-evidence-into-the-vaccine-spin/

[25] Leora I Horwitz, MD, MHS, Simon A Jones, PhD, Robert J Cerfolio, MD, Fritz Francois, MD, Joseph Greco, MD, Bret Rudy, MD, Christopher M Petrilli, MD, Trends in COVID-19 Risk-Adjusted Mortality Rates. J. Hosp. Med 2021;2;90-92. Published Online First October 23, 2020. doi:10.12788/jhm.3552

[26] Castillo et al. J Steroid Biochem and Molec Bio 2020 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7456194/pdf/main.pdf

[27] Andrew Hill, Ahmed Abdulamir, Sabeena Ahmed et al. Meta-analysis of randomized trials of ivermectin to treat SARS-CoV-2 infection, 19 January 2021, PREPRINT (Version 1) available at Research Square [https://doi.org/10.21203/rs.3.rs-148845/v1]

provisional consent, and for which the usual clinical trials will not be complete at least until 2023, considerably outweigh the risk to the majority of the New Zealand population of death or significant harm from Covid-19.

Sworn at Auckland this 21st day of April 2021

Before me:

Barrister and Solicitor/Registrar of the High Court of New Zealand

Daniel Nelson
Barrister & Solicitor of
The High Court of New Zealand